MEDICAID PURCHASE PLAN
TRANSMITTAL OF MEDICAID DISABILITY APPLICATION

Instructions: Form is to be completed by an economic support worker.

Name – Recipient (Last, First, MI)	Social Security Number
Name (County / Agency)	Caseworker Name
Telephone Number (County / Agency)	Fax Number (County / Agency)

The individual for whom the attached Medicaid Disability Application (HCF 10112) was completed, has indicated that (check one):

☐ S/he is currently employed in a paid position.

☐ S/he is participating in a Health and Employment Counseling (HEC) Program.

☐ S/he is interested in working, but is not currently working or participating in a HEC Program.

If any of the above boxes are checked, the Department of Health and Family Service's Disability Determination Bureau staff will provide to the individual and the local county/tribal social or human services department:

- A Regular Medicaid/SSI Disability Decision; and
- A Medicaid Purchase Plan (MAPP) Disability Decision.

Attach this form to the Medicaid Disability Application (HCF 10112) and confidential release forms and send to the Disability Determination Bureau at:

Disability Determination Bureau
P.O. Box 7886
Madison, WI 53707-7886